

RELEASE OF MEDICAL INFORMATION

I authorize the release of any medical information including anything related to psychiatric care, drug and alcohol abuse and HIV/AIDS. This confidential information may be necessary to process insurance claims or any utilization review. I assign all medical benefits to Acute Surgical Care, LLC. This assignment shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original.

PATIENT SIGNATURE

DATE

RELATIONSHIP IF NOT PATIENT

DATE

PATIENT NOT ABLE TO SIGN DUE TO: _____



ACUTE SURGICAL CARE

3647 J DEWEY GRAY CIRCLE, SUITE 200, AUGUSTA, GA 30909 706.504.9712 ACUTESC.COM

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